Medical/Dental History

Marchwood Dental - 1054 Halton Terrace, Kanata, ON , K2K 0G9

Before completing this form, please ensure you have the following information ready:

- Health Card number and expiry
- Name and phone number of: Family Doctor, General Dentist, Medical Specialist, and Pharmacy.
- List of medications and allergies
- Primary and secondary insurance information (if applicable)

Patient Information

Title Patient Name Date of Birth Gender

Address City Province Postal Code

Mobile Phone Home Phone Work Phone

Height (for sedation purposes) Weight (for sedation purposes) Health Card #

Health Card Expiry

Preferred method of contact?
Phone SMS Email

Preferred method of payment?
VISA MasterCard Interac

Adult Patient Child Patient

Family Doctor
Name Phone

General Dentist
Name Phone

Medical Specialist
Name Phone

Pharmacy
Name Phone Fax

In Case of Emergency, we should notify:
Name Relationship Phone

Medical Information

1. Are you being treated for any medical condition at the present or have you been treated within the past year? Yes No
If yes, please explain

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? Yes No
If yes, please explain

4. Are you taking any medications? This includes prescription or non-prescription drugs, or herbal supplements. Yes No
If yes, please list medications and dosage:

5. Do you have any allergies? Yes No
If yes, please explain

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? Yes No
If yes, please explain

7. Do you have or have you ever had asthma? Yes No
If yes, please explain

8. Do you have or have you ever had any heart or blood pressure problems? Yes No
If yes, please explain

9. Do you have or have you ever had an artificial valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Yes No
If yes, please explain

10. Do you have a prosthetic or artificial joint? Yes No
If yes, please explain

11. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, Yes No

HIV infection, radiotherapy, chemotherapy)?
If yes, please explain

12. Have you ever had hepatitis, jaundice or liver disease? Yes No
If yes, please explain

13. Do you have a bleeding problem or bleeding disorder? Yes No
If yes, please explain

14. Have you ever been hospitalized for any illness or operations? Yes No
If yes, please explain

15. Do you have or have you ever had any of the following?

chest pain, angina	shortness of breath	heart attack
rheumatic fever	mitral valve prolapse	heart murmur
pacemaker	lung disease	tuberculosis
stroke	steroid therapy	diabetes
stomach ulcers	arthritis	seizures (epilepsy)
kidney disease	thyroid disease	cancer
osteoporosis medications	drug/alcohol dependency	none of the above

I have selected all of the above that apply to me

16. Are there any conditions or diseases not listed above that you have or have had? Yes No
If yes, please explain

17. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer, heart disease)? Yes No
If yes, please explain

18. Do you or have you ever smoke or chew tobacco products? Yes No
If yes, how much do you use/when did you quit?

19. Are you nervous during dental treatment? Yes No

20. Do you or have you ever taken bisphosphonates or other anti-resorptive/bone strengthening medications? Yes No
If yes, please explain?

21. Do you consume alcohol? Yes No

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If yes, how much do you drink?

22. Do you use recreational drugs? Yes No
If yes, please explain

23. WOMEN ONLY - Are you:

Pregnant? Yes No
If yes, how many months?

Nursing? Yes No

Taking Birth Control Pills? Yes No

Dental Information

1. When was your last dental visit?

Reason:

2. How often do you visit the dentist?

3. How often do you brush your teeth?

4. How often do you floss your teeth?

5. Do any of the following cause tooth discomfort?
Cold Hot Sweets Chewing

6. Are you having any problems that require immediate attention? Yes No
If yes, please explain

7. Do your gums bleed when you brush your teeth? Yes No

8. Have you noticed any loose teeth? Yes No

9. Do you clench or grind your teeth? Yes No
If yes, do you wear a Nightguard?

10. Have you been diagnosed with sleep apnea? Yes No
If yes, do you wear a CPAP mask?

11. Have you ever had orthodontic treatment (Braces or Invisalign?) Yes No

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12. Have you been told to take antibiotics before dental appointments? Yes No

13. Have you experienced any jaw injuries? Yes No

14. Have you ever had implant surgery in your jaw? Yes No
If yes, with who and when?

15. Have you ever had any complications or issues with previous dental treatment?

16. Please list anything else not mentioned above regarding your past dental history.

Insurance Information

Insurance Coverage:
Yes No

Policy holder's name:

Policy holder's date of birth:

Your insurance company/carrier:

Group or policy number:

I.D./Certificate No.:

Employer:

Relationship to Patient:

Secondary Insurance (If Applicable):
Yes No

Second Policy holder's name:

Second Policy holder's date of birth:

Second insurance company/carrier:

Second Group or policy number:

Second I.D./Certificate No.:

Second Employer:

Relationship to Patient:

Cancellations & Missed Appointments

Your appointment time has been reserved exclusively for you to see the dentist or hygienist. We ask that you give us at least 5 business days' notice when cancelling your scheduled appointment so that we may offer the time to another patient. If you must cancel or change your appointment please call (613) 591-7608.

General Release

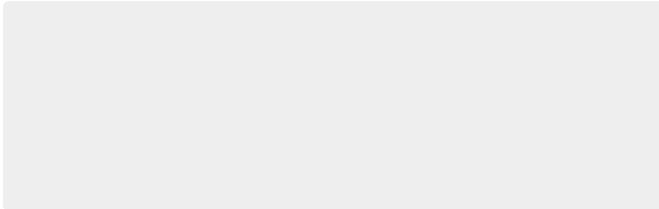
I, the undersigned, certify that I have provided an accurate and complete personal, medical and dental history, and have not knowingly omitted

any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical and dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. I authorize the dentist to perform all diagnostic procedures including and not limited to x-rays and photographs, as may be required to determine necessary treatment, and to perform necessary or advisable treatment. I understand that the dentist may use my anonymized x-rays, photographs, and other diagnostic information for the purposes of teaching, presentations, social media, and in professional dental publications. I understand that information provided from or to my medical doctor or another healthcare provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that my dental insurance may not cover entirely the total fee of services provided, and that I will be required to pay in full for the treatment with Visa, MasterCard, or Interac at the time of my appointment. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

First & Last Name

Email Address

Signature



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